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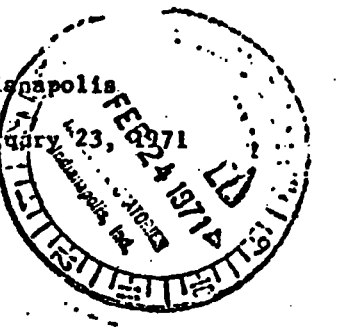
INTER-OFFICE CORRESPONDENCE

REPUBLIC CREOSOTING COMPANY

DIVISION OF REILLY TAR & CHEMICAL CORPORATION



TO: Mr. R. J. Hennessy - Reilly Lab. OFFICE: Indianapolis

FROM: R. J. Boyle DATE: February 23, 1971

SUBJECT: INSURANCE - ST. LOUIS PARK

We attach photostat of First Report of Injury sustained February 18, 1971, by James L. Lemke, who was struck on his head by a tie falling from the A. & B. Mill to the tram.

Because of the similarity of this injury to that most serious injury sustained by Joseph Just several years ago, we telephoned Mr. Finch and learned that Mr. Lemke had been released from the Methodist Hospital and had returned to work. We are most fortunate that Mr. Lemke was not injured as seriously as was Mr. Just.

This is the portion of the A. & B. Mill that we have been trying to revise to prevent injuries of this type. Mr. Finch is asking the company who recently rebuilt the A. & B. Mill to inspect the guards on the mill apron to determine if they can work out a spring lock arrangement to be activated by a foot lever to make sure that the guards are in place when the employee moves to straighten the ties.

We would appreciate any assistance you can give Mr. Finch regarding improvement in the safety features of the A. & B. Mill.

Very truly yours,

R. J. Boyle

RJB:LS

Encl.

cc: Mr. H. L. Finch - St. Louis Park

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FIRST REPORT OF INJURY

IMPORTANT: This section must be completed by the employer.

471-50-0761
Employee's Social Security Number

2-18-71
Date of Claimed Injury

29
Employer's Minnesota Withholding Tax Number

SEND THIS REPORT IN TRIPLICATE TO:

EMPLOYERS MUTUAL LIABILITY INSURANCE COMPANY OF WISCONSIN

P. O. BOX 1357 • MINNEAPOLIS, MINNESOTA 55440 • PHONE (612) 927-7941

INSURER'S MINNESOTA WITHHOLDING TAX NUMBER 0663797

WE WILL FILE A REPORT WITH THE MINNESOTA WORKMEN'S COMPENSATION COMMISSION WHEN NECESSARY.

EMPLOYEE

1. Employee name (Last) LESER (First) JAMES (M.I.) L. Tel. No. _____
2. Street address 110 ELM PARK City HOPKINS State MINN. Zip Code _____
3. Birth date 11-15-46 Sex M ☒ F ☐ Occupation MILL OPERATOR
4. Marital status-Single ☐ Married ☒ Separated ☐ Divorced ☐
5. Type of employment: Full-time ☒ Part-time ☐ Seasonal ☐ Volunteer ☐ If other, specify _____
6. Type of work program, if applicable: Apprentice ☐ GI ☐ If other, specify _____
7. Average earnings per week $ 135.00 . Check if earnings are based on piece work. ☐
8. Straight-time worked: Hours per day 8 Number of days worked per week 5
9. Average over-time worked: Hours per day _____ Number of days worked per week _____
10. Straight time rate: $ 3.37½ per hour. Over-time rate: $ _____ per hour.
11. If part-time worker, state total amount earned, total number of days worked and total number of weeks worked in the last 26 weeks. $ _____ days _____ weeks. _____ Number of hours normally worked by full-time employees per week _____
12. If furnished in addition to wages, state weekly value of: Board $ _____; Lodging $ _____; Other $ _____
13. Did employee have other regular employment at time of injury? If yes, where? _____

EMPLOYER

14. Employer REILLY TAR & CHEMICAL CORP. (PLANT # 2) Tel. No. 929-7851
15. Type of ownership: Individual ☐ Partnership ☐ Corporation ☒ If other, specify _____
16. Employer's address 7200 WALKER STREET
City ST. LOUIS PARK State MINNESOTA Zip Code 55426
17. Name of employer representative or supervisor who first received knowledge of injury R. GRAHAM
18. Date when notice was received 2-18-71 Time of day injury occurred _____ A.M. 1:15 P.M.
19. Location where injury occurred A & B MILL

NATURE AND EXTENT OF INJURY OR DISEASE

20. Nature of claimed injury or disease HEAD INJURY
21. Did claimed injury or disease cause loss of time? Yes ☒ No ☐ If yes, last day worked? 2-18-71
22. Were full wages paid for last day worked? Yes ☒ No ☐
23. Has employee returned to work? Yes ☐ No ☒ If yes, when _____
24. If injury or disease resulted in death to employee complete the following: Date of death _____
Name of dependent or next-of-kin _____ Relationship _____
Address _____

MEDICAL AND HOSPITAL

25. Name of treating physician LUTHERAN HOSPITAL Tel. No. 929-1313
Address 6500 EXCELSIOR BLVD. ST. LOUIS PARK, MINN.
26. Hospital _____ Address _____
27. Did employer authorize medical treatment? Yes ☒ No ☐

CAUSE OF INJURY

28. Describe how injury occurred WHILE LOADING TIES FROM A & B MILL TO TRUCK, HAS BENDING OVER TO STRAIGHTEN TIES ON TRUCK, FORCED TO DUCK UNDER MILL APRON, TIE FELL, HIT HIS HEAD
29. Machine, tool or appliance causing injury TIE
30. Did any employee physical handicap contribute to cause of injury? Yes ☐ No ☒ If yes, how?
31. What action has been taken to prevent recurrence? _____

Dated 2-19 19 71

(OBSERVE INSTRUCTIONS ON REVERSE SIDE.)

Signed by _____

Official Title PLANT MANAGER 219502

Phone No. 929-7851

WC 102 Dec 1969 Replaces C1 which shall not be used

5003-5005 2-70